2012 Benefits Q & A

Q: Will I have to enroll in health insurance for 2012?
A: YES, every employee who wants health insurance will need to take action and enroll in a health plan. Health insurance elections will not roll over from 2011 to 2012.

Q: What are the actual premiums for 2012?
A: The rate chart will be included in your open enrollment packet or on DER's web-site under Employee Benefits 2012:
http://city.milwaukee.gov/ImageLibrary/User/jkamme/EmployeeBenefits/2012_ActiveRateChart.pdf

Q: Has the City investigated "health savings accounts" rather than "flexible spending accounts" for employees? They don't have the "use it or lose it" clause and could save the potential loss of unexpended funds.
A: Yes, however under federal rules HAS's require the employer to have a health plan design with a minimum of $1200 single deductible and $2400 family deductible. The proposed plans do not. Employees can enroll in the City's Flexible Spending Medical program and the funds are taken pre-tax with the full amount available at the beginning of the year.

Q: What is a UHC "EPO" and are the providers the same as the UHC "PPO" we currently have?
A: EPO stands for Exclusive Provider Organization (EPO), when enrolling in UHC for 2012 it will be referred to as *UHC Choice*, this means that your physician must be a UnitedHealthcare network physician in order to receive benefits. If you are currently enrolled in UHC, you will have access to the same network physicians and hospitals. (Please be sure to always verify your provider is listed on myuhc.com or by call UHC customer service.)

Q: Did the City consider electing just one health insurance plan which would include insuring a greater number of lives in order to reduce premiums costs?
A: The City will be using UHC for the HMO style EPO plan which does not provide service out of network, and will also use UHC for the Basic Plan styled PPO plan which allows out of network services with higher deductibles and co-insurance for the out of network services vs the in-network services.

Q: If UHC EPO plan provides no out-of-network coverage and the UHC PPO plan has steerage, what happens if I'm in an accident while out of town and go to an out of network facility or provider?
A: Life threatening emergencies anywhere in this country or abroad are covered at the in-network rate with both the EPO and PPO plans. Follow-up care requires an in-network provider however, or paying out of pocket with the EPO, or paying the higher deductible and co-insurance with the PPO plan. For minor injuries and illness call the UHC number on the back of your card and they will direct you to an in-network provider throughout the country. There is no out-of-network coverage with the EPO in the event of minor injury or illness, but with the PPO there is both in-network and out-of-network coverage.

Q: For a chronic condition where CT scans and blood tests are required every 6 months, are all scans, labs and doctor visits subject to the deductable?
A: Preventive care, not treatment, is covered at 100%. All other medical services are subject to a $500 per member deductible and a 10% co-insurance for the next $5000 in services. One family member is responsible for no more than $500 deductible and no more than $500 co-insurance. If a second member has medical expenses they will be responsible for a $500 deductible as well. If there are

additional dependents the total deductible for all the household members is $1000 with no single member paying more than $500 deductible.

Q: Are annual physicals covered under PREVENTIVE, subject to deductible?
A: Certain services can be done for preventive or non-preventive (diagnostic) reasons. Generally when a service is performed during your annual preventive care visit specifically for preventive screening--and there are no known symptoms, illness or history--the services will be considered preventive care.

Q: Are lab fees associated the annual physicals covered under PREVENTIVE at 100% also?
A: Labs have to be coded as preventive to be covered at 100% but they also must be listed on the US preventive task force list (see link below.) Lab work done to test for a medical condition you already have would be subject to deductible and co-insurance so too would a lab test that's not on the list such as checking liver enzyme levels for example.
http://www.uspreventiveservicestaskforce.org/adultrec.htm

Q: I was looking at the Health Care proposed benefit package for 2012. It states Preventive Care will be covered @ 100%. Exercise is one of the best preventive care measures to prevent diseases, injury, illness, disability, and premature death. I'm interested in joining a Gym to start an exercise program which will potentially save the City health care costs in the future. If the City is covering 100% of Preventive Care, this should include Gym dues too, right?
A: Preventive is covered at 100%, but does not include gym programs. The City does not reimburse employees for their gym memberships.

Q: Spouse requires blood tests every 2 to 3 weeks due to blood thinner Coumadin and sometimes a follow up doctor office visit. Are ALL lab tests and doctor visits for this condition subject to deductible?
A: Yes, these would be subject to the $500 deductible and the 10% co-insurance for the next $5000 in services.

Q: If injured and hospitalized out of state, are we liable for 100% of the costs for out of state care?
A: Any life threatening emergency is covered as though the services were in-network. Member deductible and co-insurance will apply. Follow-up services would need to be done within the national UHC network. UHC has providers throughout the country.

Q: Is there a co-payment for Urgent Care visits? What differentiates "urgent care" from emergency?
A: No there's not a co-payment for Urgent Care Visits, but deductibles and co-insurance apply. Typically services at urgent care are significantly lower than at an emergency room.

Q: What kind of coverage will dependents that live out of state or are college students have?
A: The in-network coverage requirement is still applicable. UHC has a national provider network and can provide you with a list of in-network providers in your dependents locale. Go to www.myuhc.com or call the customer service number listed on the back of your card.

Q: Will mental health treatment be rolled into the same annual deductible and co-insurance policies of the overall health insurance benefit?
A: Yes, mental Health services would have a $500 deductible and a 10% co-insurance for the next $5000 in services until the $1000 out-of-pocket max is reached. This is not a separate deductible and co-insurance but combined with other medical services.

Q: Will UHC still have $10 office co-payments?
A: No, only a $500 deductible then a 10% co-insurance until the out-of-pocket maximum is reached.

Q: Is there a million dollar lifetime maximum for health insurance for 2012?
A: No, the cap was eliminated 1/1/10.

Q: Did the City do an RFP for drugs to try and save employees money?
A: Yes, effective 1/1/12, Medco will become the City's pharmacy benefit manager. The mail order option of ordering a 3 month supply of medication for the price of 2 months remains unchanged. The three tier co-pay will change to $5/$25/$50 in 2012. Medco will be using their formulary.

Q: Will we also be paying 12% for dental benefits? Currently we pay 70% of dental.
A: There are no changes to the dental plan. The City will continue to pay $13 for single and $37.50 per month for family. The employee is responsible for the balance.

Q: Will an active management employee who currently has Medicare and a supplement have to pay the new benefit design change of $500 deductible? They already have two insurances.
A: The City anticipates that the UHC PPO Medicare Complete Retiree plan will have the same current coverage, not the new coverage. The Basic Plan styled PPO and the UHC Choice EPO plans will have the new benefit design. The Milwaukee Retiree Association also sponsors a $0 premium plan for Medicare retirees.

Under the new benefit design with Medicare "prime" for a Medicare retiree, a Medicare Retiree would have a $500 deductible, but 75% of the second $400 is paid by Medicare, so the out of pocket share for the Medicare Retiree would be $200.

Q: Can you give me a comparison of health care costs for a person retiring this year as opposed to an employee retiring in 2012?
A: The City and the ERS will be able to do that during open enrollment. It would depend on whether you were a management employee or a represented employee or a public safety employee, if you were eligible for ordinary retirement, and whether you were single, single with dependent, two adult household or two adults with dependents.

Q: I'm in Management. If I go through regular retirement in 2011, what health insurance premium would I pay in 2011 and in 2012?
A: Management employees under age 65 who go through regular retirement have employee premiums set "the same as active employees." If the premium changes for active management employees, the premium would change for management retirees who retired after January 1, 2009. Your "premium" is not fixed at one price while you are under 65, but is the same as other management employees. Yes, your employee premium will change in 2012, and yes, your benefit design will change in 2012.

Q: In the past the Basic Plan was an open plan. The information now mentions in-network and out-of-network costs. Isn't this the same as an HMO? What "network" is being considered?
A: The Basic Plan styled PPO plan has always had "in-network" and 'out of network." The only steerage was the plan paid "usual and customary fees" which meant that an in-network provider would accept usual and customary as payment in full, while an out of network provider could "balance bill" the member for the amounts over usual and customary. This will change with actual steerage in the proposed Basic Plan. The plan still allows an employee to see any provider. Under the current Basic

Plan about 98% of the utilization was in-network. It is not expected it will change. Employees will have access to the same in-network under the HMO plan. In 2012 the Basic plan will be referred to as, UHC *Choice Plus*.

Q: If I have a family of 4 (2 adults & 2 children), is my maximum out of pocket going to be $1000 or $4000?
A: Each member of the household has no more than a $500 deductible and the family has "no more than" a $1000 deductible. Each member has no more than $500 co-insurance, and the total co-insurance for a family is $1000. When a "family" reaches their $2000 out of pocket maximum the plan will pay at 100% for additional medical services with the exception of emergency room services that have a $150 co-pay. The maximum out of pocket is not $4000.

Q: Currently 100% of all maternity benefits are covered under the existing health plan, office visits, tests, delivery expenses. Will this benefit be impacted by the proposed change?
A: Physician services and hospital services related to the birth will be subject to the plan's deductible and co-insurance. Typically your clinician will submit one "global" bill for maternity care and delivery post-partum, although charges can be submitted more frequently. Newborns may incur charges subject to deductible/co-insurance if they require more than routine medical care.

Q: The definition of terms page does not define preventive care. Can you please define "preventive care" and provide typical examples of services that would fall into this category?
A: Typically an annual physical, appropriate age and gender screenings as well as screenings based on your medical history are preventive. Treatment of an illness is treatment, not preventive. See the DER website for more information at:
http://city.milwaukee.gov/ImageLibrary/User/jkamme/EmployeeBenefits/PreventativeCare.pdf

You may also find more information at: www.uhcpreventivecare.com

Q: In the co-pay section on the definition of terms, it is not disclosed if co-pays are required for provider visits, labs, and/or testing. And, if so, what these prices are for both the HMO/Basic Plan. Please provide clarification on these items.
A: The only "co-pay" is for emergency room after a member or household has reached their out of pocket maximum. There are no co-pays for doctor office visits or other lab work, but member deductible and co-insurance applies to all medical services.

Q: On the UHC web-site, which "plan" should I be selecting from the drop-down menu to get to the City's plans?
A: For the EPO plan, select "*UnitedHealthcare Choice*;" PPO plan "*UnitedHealthcare Choice Plus*."